Rooted in Strengths: The Branching of Interprofessional Practice and Education

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"*…all the branches of a tree at every stage of its height when put together are equal in thickness to the trunk*" (The Notebooks of Leonardo Da Vinci, No. 394, Richter, 1970, as cited in Eloy, 2011, p. 1).

Since the 1989 publication of 'A Strengths Perspective for Social Work Practice' in the journal *Social Work* by University of Kansas researchers, the strengths perspective has represented the sturdy trunk of a tree nourished by the deep-seated values of the social work profession. Its introduction served to prune the dead branches of "moral deficiency," "human failing," and "pathology" (Weick, Rapp, Sullivan, & Kisthardt, 1989, p. 350) born of problem-focused approaches to human behavior and arising from the long shadow of Abraham Flexner and the influence of the medical model upon the development of professions (Gitterman, 2014). Its adoption encouraged the new growth of healthy branches supporting the intrinsic strengths of "peoples and society," ultimately bearing fruit representing "some of the deepest values of social work" (Weick et al., p. 350).

An off-shoot of the strengths perspective, strengths-based case management (SBCM), was first demonstrated to be effective with individuals transitioning into the community from state psychiatric hospitals (Rapp & Chamberlain, 1985). A study by Siegal, Rapp, Li, Saha, and Kirsk (1997) suggested that "SBCM may operate as a stand-alone treatment intervention, rather than just as an adjunct to treatment" (as cited in Rapp, 2007, p. 185). In 2001, Marty, Rapp, and Carlson contributed a tool that assessed key elements of SBCM, and in 2006, Saleebey developed a conceptual foundation for the strengths perspective (as cited in Rapp, 2007).

Subsequently, SBCM was extended from its original behavioral health application to the treatment of individuals living with substance use disorders and HIV. The ap-

proach was credited with improved aftercare retention and "reduced drug use and criminal justice involvement" for individuals with substance use disorders (Rapp, Siegal, Li, & Saha, 1998; Siegal et al, 1996; Siegal, Li, & Rapp, 2002, as cited in Rapp, 2007, p. 185). SBCM was later found effective linking recently diagnosed HIV-infected individuals with HIV medical care (Craw, Gardner, Marks, Rapp, Bosshart, Duffus, Rossman, Coughlin, Gruber, Safford, Overton, & Schmitt, 2008). Each of these approaches served to leverage the strengths of individuals, while focusing on the skills and abilities of strengths-based case managers, rather than teams, to facilitate successful care transitions and aftercare.

In 2012, Gottlieb, Gottlieb, and Shamian posited that the "strengths-based movement has the potential to become a 'game-changer' in nursing and to transform healthcare" (p. 40), transitioning from a fragmented, depersonalized, less accessible "disease/illness model" to one "in which people and communities assume greater control and responsibility for their own health and healthcare decisions" (Frist, 2005, as cited in Gottlieb et al., p. 39). The proposed route to this change was through Strengths-Based Nursing Leadership (Gottlieb et al., 2012) and Strengths-Based Nursing Care (Gottlieb, 2012).

Strengths-Based Nursing Care focused on "understanding, uncovering, discovering and releasing biological, intrapersonal, interpersonal and social strengths to deal with challenges and to meet personal, team and system goals" and to "get the most out of what is important and meaningful to them," while focusing on the nurse-person relationship as central to the healing process (Gottlieb et al., 2012, p. 41). As a theoretical perspective, SBC valued person- and family-centered care, empowerment, whole-person care, context-based care, health promotion and illness prevention, self-care, and collaborative partnership involving "a collaborative relationship between the person/family and the healthcare provider" (p. 41). While embracing and articulating important strengths-based values and addressing people, teams and systems, SBC was still framed around a specific profession and their relationship with the person and family at the center of care.

Although focused on the inherent strengths of people and society, the strengths perspective was often framed around a specific role (i.e., case manager), profession (e.g., social worker or nurse), or process (i.e., strengths-based case management, strength-based nursing care) as they related to the care of individuals and families, rather than to the interprofessional team or team-based care. This presents an opportunity to apply the strengths perspective to an interprofessional team-based approach to health and social care.

This chapter will explore the development of interprofessional practice and education (IPE) and the evolving role of the patient voice through the lens of the strengths perspective. It will propose a new model of Strengths-Based Interprofessional Practice and Education (SB-IPE) incorporating appreciative inquiry and narrative

methods. Opportunities to advance a model of strengths-based interprofessional practice, education, policy, research, and theory are explored.

INTERPROFESSIONAL PRACTICE AND EDUCATION

> *Interprofessional practice and education has the "potential to transform health care and health professions education" (NCIPE, 2015, b, para 3).*

According to the World Health Organization, *interprofessional education* occurs "when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010, p. 13). Interprofessional practice and education (IPE) has experienced "a long history of ebbs and flows of interest, resurgence and refocus for over 50 years" (Brandt & Schmitt, 2013, as cited in Brandt, 2014, p. 6), and has been referred to as "the 'new' forty-year-old field" (Brandt, 2015, p. 9). The field has also experienced evolving language from interprofessional education (IPE), to interprofessional education and collaborative practice (IPE/CP), to the current *interprofessional practice and education* (the new IPE) (National Center for Interprofessional Practice and Education, 2015). During the 1960s and 1970s, "interprofessional education" took hold as a promising practice exploring "what students should learn together and how they should learn it" (Gilbert, 2010, as cited in Fransworth, Seikel, Hudock, & Holst, 2015, p. 1). Alternating between "interdisciplinary education" and "interprofessional education," a 1972 Institute of Medicine report recommended that academic health centers and "regional consortia of health professions schools…foster educational teamwork" ("Highlights of Recommendations"). See Table 1 for a brief history of IPE in the United States.

The social work profession shares a noteworthy role in the history of IPE. Beginning as a nascent concept of "interprofessional" collaboration between medicine and social work (Cabot, 1901, as cited in Schmitt, Gilbert, Brandt, & Weinstein, 2013), the earliest known use of the phrase "interprofessional education" involved a collaboration between psychology and social workers (Dickson, Levinson, Leader, & Stamm, 1949, as cited in Kennedy, 2020). The first use of the phrase "interprofessional team" occurred in a trio of three publications by social work educator and researcher, Rosalie Kane, including a doctoral dissertation (1975, June) and two workforce monographs (1975, a; 1975, b).

The origins of IPE in healthcare can be traced to the early 2000s, when the Institute of Medicine (IOM) released a trio of reports: *To Err is Human* (2000), *Crossing the Quality Chasm* (2001), and *Health Professions Education: A Bridge to Quality* (2003). These three groundbreaking reports focused on patient safety, quality imperatives, and workforce optimization, concentrating interest in health system redesign and the importance of IPE.

In 2010 the World Health Organization (WHO) released *Framework for Action on Interprofessional Education & Collaborative Practice*, laying the groundwork to advance the field of IPE by creating common language and meanings. In addition to defining interprofessional education, as previously noted, *collaborative practice* in health-care was defined as occurring "when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings" (WHO, 2010, p. 13). Importantly, WHO defined *health workers* as "wholly inclusive… [of] those who promote and preserve health…whether regulated or non-regulated, conventional or complementary" (2010, p. 13) and *professional* was framed as "an all-encompassing term that includes individuals with the knowledge and/or skills to contribute to the physical, mental and social well-being of a community" (p. 13).

These inclusive definitions by WHO have highlighted the individual and collective value of each member of the healthcare team and fostered the participation of direct care workers, community health workers (CHWs), lay health educators, and other individuals who make important contributions to health and social care as members of the interprofessional team. CHWs who are members of the populations they serve, including *promotoras* or *promotoras de salud* (Spanish for "health promoters") (Deitrick, Paxton, Rivera, Gertner, Biery, Letcher, Lahoz, Maldonado, & Salas-Lopez, 2010, p. 386) and traditional or indigenous healers (Moorehead, Gone, & December 2015), foster health and wellness by honoring and unleashing the strengths of culture and language that reside within people and communities (Knutson Woods, Blaine, & Francisco, 2002).

A significant milestone occurred in 2010 with passage of the Patient Protection and Affordable Care Act (U.S. Congress), also referred to as the ACA and Obamacare. The ACA established "community-based interdisciplinary, interprofessional teams…to provide support services to primary care providers" (p. 435) and advanced several concepts and measures supporting patient-centered care (see The Patient Voice).

In 2011, the Interprofessional Education Collaborative (IPEC) established four core competencies, and related sub-competencies, for interprofessional collaborative practice:

- *values/ethics for interprofessional practice*
- *roles/responsibilities*
- *interprofessional communication*
- *teams and teamwork*

These competencies reinforced the strengths and unique contributions that each member of the healthcare team brings to the process of health and social care. They recognized the importance of each discipline's foundational values and ethics, contribution of unique and navigation of overlapping roles/responsibilities, and the

interplay between disciplines through interprofessional communication and teams/teamwork.

In 2016, IPEC released an update that organized the four core competencies within a single domain of interprofessional collaboration and broadened the competencies to better achieve the Triple Aim, with an emphasis on population health. Evidence in support of this focus on interprofessional collaboration was compelling. The presence of collaboration within hospitals was found to have reduced rates of mortality, negative patient outcomes, and costs; and increased organizational commitment, and provider satisfaction and responsiveness (McKay & Crippen, 2008, p. 109). On the other hand, the absence of collaboration was found to be "a contributing factor to the fragmentation of care and poor outcomes which plague our healthcare system" (Henneman, Lee, & Cohen, 1995, as cited in McKay et at., p. 109).

Table 1: Time Capsule of Interprofessional Practice and Education in the United States (Kennedy, 2020)

Year	Milestone	Publication
1901	Concept of "interprofessional" teamwork emerged from a collaboration between medicine and social work	(Cabot, as cited in Schmitt, Gilbert, Brandt, & Weinstein, 2013)
1949	Newly discovered earliest use of "interprofessional education" between psychology and social work	(Dickson et al., as cited in Kennedy, 2020)
1969	Previously reported early use of "interprofessional education"	Interprofessional Education in the Health Sciences
1972	Suggested fostering "educational teamwork" through consortia of academic health centers and health professions schools ("Highlights of Recommendations")	Educating for the Health Team (IOM)
1975	First known use of "interprofessional team"	The Interprofessional Team (Kane, June; 1975, a; 1975, b)
2000	Addressed the role of health care providers to improve patient safety and reduce medical errors	To Err is Human (IOM)
2001	Envisioned a health system that is safe, patient-centered, timely, efficient, and equitable with new roles/responsibilities for health care workers	Crossing the Quality Chasm (IOM)
2003	Proposed educating all health professionals "to deliver patient-centered care as members of an interdisciplinary team" (p. 3)	Health Professions Education: A Bridge to Quality (IOM)

Table 1: (continued)

2010	Established definitions for "interprofessional education" and "collaborative practice" (p. 13)	Framework for Action in Interprofessional Education and Collaborative Practice (WHO)
2010	Established "community-based interdisciplinary, interprofessional teams" and advanced patient-centered care provisions	Patient Protection and Affordable Care Act (U.S. Congress)
2011	Addressed the role of nursing in health care redesign, as equal partners at full scope of practice	The Future of Nursing: Leading Change, Advancing Health (IOM)
2011	Established core and sub-competencies for IPE	Core Competencies for Interprofessional Collaborative Practice (IPEC)
2012	Creation of the National Center for Interprofessional Practice and Education in the United States	Coordinating Center for Interprofessional Education and Collaborative Practice: Funding Opportunity Announcements. (US Department of Health and Human Services)
2015	Introduced the interprofessional learning continuum conceptual model linking the education-to-practice continuum, learning and health-related outcomes, and enabling and interfering factors	Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes (IOM)
2015	interprofessional practice and education (the "new IPE")	National Center for Interprofessional Practice and Education (NCIPE, a)
2016	Organized core competencies within the single domain of interprofessional collaboration and broadened competencies to better achieve the Triple Aim, emphasizing population health	Core Competencies for Interprofessional Collaborative Practice: 2016 Update (IPEC)
2019	Voluntary harmonization of terminology and consensus guidelines related to accreditation of IPE for 24-member health professions accrediting agencies	Guidance of Developing Quality Interprofessional Education for the Health Professions (HPAC)
2019	Identified key characteristics of high-functioning interprofessional clinical learning environments (IP-CLEs) including "patient-centeredness, continuum of learning, reliable communications, team-based care, shared accountability, and evidence-based practice" (Weiss et al., p. 9)	Achieving the Optimal Interprofessional Clinical Learning Environment (NCICLE)

The promise of interprofessional practice and education (IPE) is to improve the experience of care for people, improve the health of populations, and reduce the per capita cost (or improve the value) of care, known as the Triple Aim (Berwick, Nolan, & Whittington, 2007). In 2014, this concept was expanded to include improving the experience of providers, referred to as the Quadruple Aim (Bodenheimer & Sinsky), amidst mounting evidence of the impact of provider burnout and resulting turnover on quality of care and workforce retention.

Notwithstanding the promise of IPE, a sobering 2014 scoping review revealed that "despite a four-decade history of inquiry into IPE and/or collaborative practice, scholars have not yet demonstrated [its]…impact…on simultaneously improving population health, reducing healthcare costs or improving the quality of delivered care and patients' experiences of care received" (Brandt, Lutfiyya, King, & Chioreso, p. 393). In response to this challenge, Pechacek, Cerra, Brandt, Lutfiyya, and Delaney (2015) proposed the development of a national intervention network and "National Center Data Repository" (p. 146). This strategy involved identifying and promoting the use of validated instruments and a common core data set permitting national comparisons while promoting intervention research designs and processes (p. 152). As a result of these strategies, research linking interprofessional team-based practice to Triple and Quadruple Aim outcomes--improving the quality and experience of care for people, populations, and providers, while reducing price—has begun to bear fruit. A study by Guck, Potthoff, Walters, Doll, Greene, and DeFreece demonstrated improved patient outcomes (e.g., reduced emergency room visits and hospitalizations, and reduced A1C levels), as well as a dramatic reduction in costs of care (48.2%), for a cohort of high-risk patients, served through an interprofessional collaborative practice model as compared with usual care (2019, p. S82).

On a national level, the National Center for Interprofessional Practice and Education (NCIPE) released important findings in 2019 from the Accelerating Interprofessional Community-Based Education and Practice initiative, spanning 16 sites in 14 states, adding to the evidence-base linking IPE to Triple Aim outcomes. Through the development of interprofessional academic-practice partnerships serving vulnerable populations at the nexus of interprofessional education and collaborative practice, "[m]any sites were starting to see improved health outcomes for patients by the end of the [two-year] grant period" (Harder + Company Community Research, 2019, p. 4). Initial patient- and population-level health outcomes included improved access to primary care, reduced emergency department visits and hospital readmissions, improvements in A1C indicators for people living with diabetes, and improved patient reports of satisfaction with their care (pp. 28-29).

In early 2019, the Health Professions Accreditors Collaborative (HPAC) released a guidance presenting a voluntary harmonization of accreditation standards endorsed by 24 health professions accreditors, including "consensus terminology and definitions" (HPAC, p. 6). Finally, the National Academies of Sciences, Engineering, and Medicine (NASEM) recommended strengthening health professions education and

practice alignment, shifting the preparation of health professionals from a focus on acute care to meet the burgeoning demand for ambulatory and home-based care, and developing new models of care, delivery, and payment that broadened the concept of the health workforce (NASEM, 2019, p. 6).

Interprofessional practice and education (IPE) holds the promise of improving care for people, populations, and providers, while reducing price, and seeks to eliminate health and health care disparities. In combination with IPE, the strengths perspective can be leveraged to underscore the valuable perspectives and contributions of, and overlaps and relationships between, all members of the interprofessional team. It is an inclusive practice that harnesses the strengths of the values and ethics and roles and responsibilities of health and social care providers across disciplines, encompassing direct care workers, community health workers, and lay health educators and bringing forth the strengths of culture and language in partnership with people and communities. Leveraging strengths is also important to leadership in IPE, informing a model of spontaneous leadership "where all members of the team can provide leadership at different times depending on their strengths, skills and the situation" (Harder + Company Community Research, 2019, p. 22). In these ways, the strengths perspective offers an essential ingredient required to foster the effectiveness of IPE.

THE PATIENT VOICE

> *"The road map to the future in health care is driven by patients and families, leading out of the hospital into outpatient, community and home settings. It's ambitious, noble and challenging work that is pivotal to the future of health systems and health professions education."* (NCIPE, 2019)

From the beginning, the strengths perspective valued the patient voice, believing that "people have the capacity to determine what is best for them" (Weick and Pope, 1988, as cited in Weick et al., 1989, p. 353) and that even "in the midst of complexity, people proceed in the best way they can" (p. 353). The notion of agency has undergone dramatic changes over time as a result of the introduction of strengths-based principles.

In 1957, the American Medical Association's Code of Ethics framed patient opinions as a"[r]easonable indulgence…granted to the caprices of the sick" (AMA, as cited in Millenson & Macri, p. 1). During the 1960s and 1970s, the patient's role began to transform as a result of three concepts: the ethical notion of "patient autonomy as a human right that supersedes physician beneficence" (p. 1), the economic notion of "health care as a marketplace filled with consumers and providers weighing costs and benefits" (Millenson & Macri, 2012, p. 1), and the clinical notion of the "patient's voice" represented in the shift toward "patient-reported outcomes, such as physical functioning…that could provide feedback about ongoing treatment decisions" (p. 2).

In 2001, an Institute of Medicine report, Crossing the Quality Chasm: A New Health System for the 21st Century, recommended "fundamental change" to the American healthcare system, suggesting that "[h]ealth care should be…Patient-centered—providing care that is respectful and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (p. 40). The report outlined six "dimensions of patient-centered care: (1) respect for patients' values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support—relieving fear and anxiety; and (6) involvement of family and friends" (Gerteis, Edgman-Levitan, & Daley, 1993, as cited in IOM, 2001, p. 49).

In 2010, along with defining interprofessional education and collaborative practice, the World Health Organization established six learning outcomes for a *collaborative practice-ready health workforce*, including "recognizing the needs of, the patient" (p. 26). Also in 2010, the Patient Protection and Affordable Care Act (U.S. Congress), frequently referred to as the ACA or Obamacare, mandated the use of "quality measures" that translated to "patient-centered assessments," referencing "patient-centeredness, patient satisfaction, patient experience of care, patient engagement, and shared decision-making" (Millenson & Macri, 2012, p. 1).

Subtitle F—Health Care Quality Improvements, established the concept of the Patient-Centered Medical Home and introduced a mechanism to support grants or contracts "to establish community-based interdisciplinary, interprofessional teams…to support primary care practices…within the hospital services areas." Care was to include "prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available" (Sec. 3502, (b) Eligible Entities, (3), p. 435) and "services to eligible individuals with chronic conditions" (Sec. 3502, (b) Eligible Entities, (5), p. 435). Health care teams were required to "support patient-centered medical homes, defined as a mode of care that included "whole person orientation; coordinated and integrated care; [and] expanded access to care" (Sec. 3502, (c) Requirements for Health Teams, (2), A-E, p. 436)

In 2019, the National Academies of Sciences, Engineering, and Medicine (NASEM) recognized the value of incorporating the potential "disruption of patient and family voices and perspectives" (p. 24), as well as "care delivery innovation" (p. 56) into health professions education. The same year, the National Collaborative for Improving the Clinical Learning Environment (NCICLE) released two reports. The first focused on the importance and key characteristics of high-functioning interprofessional clinical learning environments (IP-CLE) in preparing the current and future workforce (Weiss, Passiment, Riordan, & Wagner, 2019, p. 3) for "patient-centeredness, continuum of learning, reliable communications, team-based care, shared accountability, and evidence-based practice centered on interprofessional care" (p. 9). The second addressed the need for "all levels of the health care system" to focus quality improvement efforts on the elimination of health and health care disparities

and to prepare future clinicians accordingly (Casey, Chisholm-Burns, Passiment, Wagner, Riordan, & Weiss, 2019, p. 3). Using a patient-centered orientation, *quality improvement* was defined as the "frameworks used to systematically improve the ways care is delivered to patients" (p. 17).

Shifting from Patient-Centered to Person-Centered Care

> "*There is a relation between persons and role… the culture itself prescribing what sort of entity we must believe ourselves to be in order to have something to show through in this manner*."
> (Goffman, as cited in Wilson, 1988, p. 93)

In 2011, Starfield contended that a patient-centered care perspective was insufficient, arguing for person-focused care. She presented a compelling case that in a patient-oriented perspective care entailed visit-based, episodic interactions focused on disease management of a given number of chronic conditions and distinct body-systems, used professionally-defined conditions based on coding (for billing purposes), and was primarily concerned with disease evolution. In addition to its focus on the person as a role (i.e., patient), this approach is designed with the provider and health system in mind. In contrast, person-focused care (or *person-centered care*) focused upon the person, interrelationships between the individual and provider over time, viewed illnesses as an individual's life-course experience of their health, regarded diseases and body systems as interrelated, saw health conditions as multimorbid, used coding systems as opportunities to reflect on individual's health concerns (e.g., social determinants of health), and was as concerned with an individual's experienced health challenges as with their diseases (p. 63) (see Table 2).

Table 2: Patient-Centered Care versus Person-Focused Care

Patient-Centered Care	Person-Focused Care
Interactions during visits	Interrelationships over time
Episode-oriented experience with health	Episodes as part of life-course experiences
Management of diseases	Diseases as interrelated phenomenon
Comorbidity (number of chronic diseases)	Multimorbidity (combinations of illnesses)
Body systems: distinct	Body systems: interrelated
Coding systems: professionally defined conditions	Coding systems: people's health concerns
Evolution of patient's diseases	Evolution of people's experienced health problems and diseases

(Adapted from Starfield, 2011, p. 63)

Starfield introduced a critical paradigm shift to our approach to care. Patient-centered care focused on the role of patient, albeit temporary and one of a panoply of roles played over a lifetime, while person-centered care focused on personhood. In this construction, the role of the patient is a minor character in a play that spans a lifetime and a wide array of roles, reminiscent of Goffman (1956).

It is critical that health and social care professionals make this transition from role-focused care to person-centered care. The advancement of person-centered care principles through advocacy, education, and policy reform has led to two powerful, yet exquisitely simple, guiding principles: ask what matters and do nothing about me without me. Application of the strengths perspective holds promise for advancing an interprofessional team-based approach to care in which individuals and families are essential members and active participants in, versus simply the focus of, the interprofessional team.

A NEW BRANCH ROOTED IN STRENGTHS: STRENGTHS-BASED INTERPROFESSIONAL PRACTICE AND EDUCATION

While listening to the voices of people, families, and communities as members of the interprofessional team is important to the delivery of health and social care, these same voices can be harnessed to inform a simultaneous redesign of education health and social care. Likewise, it is important to listen to the voices of practitioners, interprofessional teams, and value the collective experience of organizations.

Within communities, organizations, and systems are people who understand their assets and cultures, hold a collective wisdom derived from their shared history and individual biographies, and are deeply invested in their success. This wisdom and experience can be mined for strengths and best practices. Incorporating such wisdom and experience can inform the development of a new model of IPE, Strengths-Based Interprofessional Practice and Education (SB-IPE).

The strengths perspective can be harnessed in service of the goal of managing the change required for simultaneous systems transformation of education and health and social care through SB-IPE. Two promising approaches to advance this new model include *appreciative inquiry* and the use of *narrative methods*.

Appreciative Inquiry and Strengths-Based Interprofessional Practice and Education

> *"Appreciation is about valuing the life-giving in ways that serve to inspire our co-constructed future. Inquiry is the experience of mystery, moving beyond the edge of the known to the unknown, which then changes our lives…where appreciation and inquiry*

> *are wonderfully entangled, we experience knowledge alive and an ever-expansive inauguration of our world to new possibilities."* (Cooperrider & Srivastva, 2017, p. 4)

Appreciative inquiry (AI), formulated in 1987 by Cooperrider and Srivastva, is a constructivist approach "to initiating and managing organizational change" (Dematteo & Reeves, 2011, p. 203) that serves as both "an organizational theory and a tool of social change" (Cojocaru, 2012, p. 122).

> At its heart, AI is about the search for the best in people, their organizations, and the strengths-filled, opportunity-rich world around them. AI is not so much a shift in the methods and models of organizational change, but AI is a fundamental shift in the overall perspective taken throughout the entire change process to 'see' the wholeness of the human system and to "inquire" into that system's strengths, possibilities, and successes. (Stavros, Godwin, & Cooperrider, 2015, p.97).

Four guiding principles are at the heart of AI: Research into the social innovation potential of organizational life should begin with appreciation and should be applicable, provocative, and collaborative (Cooperrider & Srivastva, 2017, p. 55). AI was part of the root structure of strengths-based management (Cooperrider, 2017) and has been described as "arguably the most powerful process of positive organizational change ever devised" (Gergen, from Whitney, Trosken-Bloom, & Rader, 2010, p. x, as cited in Cooperrider, 2017, p. 5).

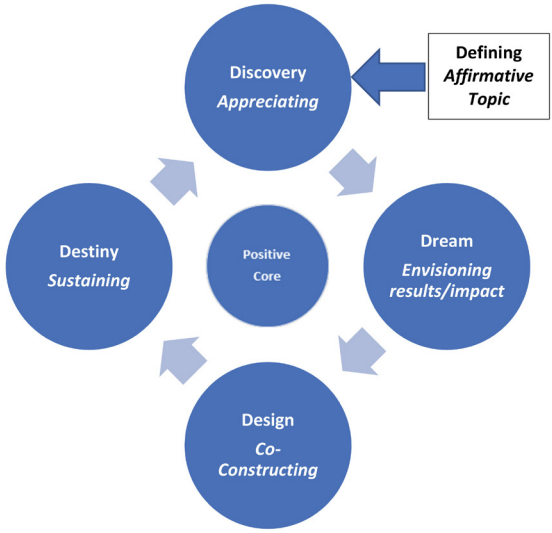

Figure 1: Appreciative Inquiry as a Strengths Perspective. (Adapted from Stavros, Godwin, and Cooperrider, 2015)

MacFarlane (2006) observed that the strengths perspective was "echoed in several theoretical frameworks" including AI, with which it shared "basic assumptions and techniques" (p. 176). The use of AI as a strengths-based approach to patient care transitions was explored by Shendell-Falik, Feinson, and Mohr (2007). Hospital staff used AI to address serious patient safety issues related to patient care transitions, attributed to up to 98,000 death each year (IOM, 2000 and 2001, as cited in Shendell-Falik et al., 2007). AI focused on strengths, in this case identifying and building upon effective patient care transitions. Related outcomes, "such as using resources more efficiently, better documentation and user-designed communication tools, resulted in better patient safety and economic efficiency" (Shendell-Falik et al., 2007, as cited in Sims-Gould et al., 2012, p. 206). In fact, "growing evidence of the benefits of using a strengths-based approach may outweigh a traditional focus on identifying problems in care transitions" (Sims-Gould et al., 2007, p. 206).

Moore and Charvat (2007) described the application of AI to "health promotion and behavior change" (S64) for a population of underserved women experiencing health disparities by giving "voice to [their]…hopes and dreams regarding their health and to assist them in finding the energy to move toward healthier behaviors" (p. S65). In this usage, AI reflected the tenets of strengths-based case management.

A 2012 study sought to understand how interprofessional health care providers sought to identify "success" in post-hip fracture care transitions using a strengths-based perspective to system improvement. "[H]allmarks of 'success' [included] a focus on process—information gathering and communication, and a focus on outcomes—autonomy and care pathways" (Sims-Gould, Byrne, Hicks, Khan, & Stolee, p. 205).

> Because an appreciative approach stresses supportive relationships and shared vision over problem-solving it seemed to have special resonance for those working in health care given the hierarchical interprofessional relationships that exist…[and] appeared to engender positive perceptions of interprofessional collaboration, as indicated in participants' reports of high levels of enthusiasm and commitment for this type of work which can be difficult to undertake (Dematteo & Reeves, 2011, p. 207).

While extolling the potential of AI to advance interprofessional education initiatives, Dematteo and Reeves warn that without an appreciation of the "broader social, economic, and political context," (Grant & Humphries, 2006, p. 405, as cited in Dematteo & Reeves, 2011, p. 204), AI can "overlook a number of structural factors, which will ultimately limit its ability to…secure meaningful and lasting change within health care" (2011, p. 203). Still, Cooperrider (2017) posits that "very few of the hundreds of applications…go to…the key concept of AI as a generative theory building method for the collaborative construction of reality" (p. 5). Given that IPE requires a "collaborative relationship between the person/family and the healthcare

provider" (McKay & Crippen, 2008, p. 41) and education and healthcare transformation are fostered by collaborative, co-created academic-practice partnerships, Cooperrider's and Srivastva's concept of a "collaborative construction of reality" (2017, p. 5) serves as a good fit with IPE.

A 2010 study by Conn, Oandasan, Creede, Jakubovicz, and Wilson applied AI to a two-year organizational change process advancing interprofessional teamwork within a family health team. The authors learned that practice change (e.g., a shift to patient-centered care), or first-order change, "precede[d] change in…the way that members [spoke and thought]…about themselves as an integrated team," or second-order change (p. 284). This finding suggests that AI serves as an initial step in the process of change, but that it may benefit from a paired approach that fosters the necessary second-order change to sustain culture change.

While AI offers a powerful approach to organizational and system change, the process of defining an affirmative topic and moving through the cycle of appreciating, envisioning results and impact, co-constructing, and sustaining, inevitably involves story and narrative. Partnered with AI, the use of narrative could be the missing ingredient to promote second-order change, facilitating the process of eliciting, co-creating, and coalescing the story of change necessary to achieve strengths-based IPE.

Narrative Approaches to Strengths-Based Interprofessional Practice and Education

> *"[N]arrative methods, patient-centered practice, and interprofessional teamwork are all interrelated and have the common goal of improving…care and quality of life*" (Clark, 2015, p. 177).

Providing health and social care from a person- and family-centered perspective is a process of eliciting, listening to, and processing stories and narratives from the patient history, assessment, and care plan, through treatment, care transitions, discharge, and aftercare. Each member of the healthcare team brings their own unique filter to this information based upon their profession's values, socialization, and unique focus.

The process of working with a person and family in the context of interprofessional team-based care involves a process of coalescing the person/practitioner narratives and co-creating a person/team narrative.

> Thus, each professional will co-create, with the patient, a different narrative; when the providers come together as an interprofessional team, it is essential that these different stories be recognized as such and effectively integrated into an overall assessment

> and care plan that incorporates many clinical voices. (Clark, 2015, p. 177)

Shared decision making (SDM) is an approach designed to foster patient-centered care facilitate mutually agreed health care choices between patients and practitioners that are "respectful and responsive to individual patient preferences and needs, and reach clinical decisions…guided by patient values" (Stacey, Légaré, Pouliot, Kryworuchko, & Dunn, 2010, p. 164). Within the Affordable Care Act, *patient engagement* was defined as "the active participation of patients and their families in the process of making medical decisions," while *shared decision-making* was defined as "decision support tools and…methods with which the patient can assess the merits of various treatment options in the context of his or her values and convictions" (as cited in Millenson & Macri, 2012, p. 2). While SDM has been found to be an important contribution to person-centered care, Stacey et al. reviewed 15 unique models of SDM, finding that the few including at least two health professions did not reflect interprofessional collaboration (2010).

> "Person-centred care necessitates that practitioners learn more about the…person as an individual, together with a better understanding of the patient's personal meanings, experiences, and attitudes" (Clarke, 2001, p. 698, as cited in Clark, 2015, p. 178).
>
> This means looking beyond the "mask" of age, illness, and disability to see the person's true self and life. In addition, it connotes the development of a genuine relationship with the patient that reveals underlying values in terms of the choices facing him or her and the constraints on those choices that may exist. (McCormack, 2004, as cited in Clark, 2015, p. 178)

Having a relationship with, and recognizing the needs of, the patient includes "working collaboratively in the best interests of the patient" and "engaging with patients, their families, carers and communities as partners in care management" (WHO, 2010, p. 26). On a system and community level, "[i]ntegrating community members (patients and families) into healthcare delivery planning could enhance engagement in personal health, leading to reduced chronic disease and improved population health" (Pechacek et al., 2015, p. 151).

Considerations for Education, Practice, Policy, Research, and Theory

Academic-practice partnerships and simultaneous system redesign of education and healthcare are grounded in person-centered principles with people, families, and communities as fully participating members of the interprofessional team. Opportunities are ripe to advance SB-IPE practice, education, policy, and research through AI and narrative.

Practice

In practice, SB-IPE could harness the shared voices of people, populations, and professions using appreciative inquiry and narrative to imagine a better system of health care that eliminates health and health care disparities and meets the needs of all people. The 2019 guidance by the National Collaborative for Improving the Clinical Learning Environment can serve as a roadmap to engage and prepare the current and future workforce to work at "all levels of the health care system" (Casey, Chisholm-Burns, Passiment, Wagner, Riordan, & Weiss, 2019, p. 3) towards the elimination of "health care disparities as a unique component of health disparities" (p. 5). In community settings, students and practitioners can be recruited and trained to "work with the community at large to analyze population health data to identify risk factors and root causes that contribute to disease and health outcomes" (Advisory Committee on Interdisciplinary, Community-Based Linkages, 2019, p. 10).

Education

The process of professional identity formation in health professions education requires a parallel process guiding interprofessional identity formation. The latter would improve individual and team navigation of the core competencies of interprofessional collaboration for students and practitioners, namely values and ethics, interprofessional communication, roles and responsibilities, and teams and teamwork. Such training could include learning to operate as border crossers or "boundary spanners… position[ing] students well for work in the increasingly interprofessional realms of health and social care…Seeing [them]selves as boundary spanners is one way to reconcile…professional and interprofessional identities…when they move into interprofessional practice" (Oliver, 2013, Abstract, p. 773). In education, SB-IPE could harness the individual and collective voices of health professionals, educators, and students to co-create an interprofessional identity formation process and boundary spanner role. Such an inquiry could also inform and advance a model of interprofessional spontaneous leadership (Harder + Company Community Research, 2019, p. 22).

Policy

Through the use of AI and narrative and leveraging informatics, reimbursement models could be transformed by identifying person-focused coding specifying perceived health concerns. An example of this work is being conducted by UnitedHealthcare, who are "incorporating social determinants into clinician workflow to improve care management and enhance health" (Shapiro, 2019, slide 9). Such coding could be cross-referenced with social determinants of health and leveraged to inform and tailor approaches to population health. In policy, SB-IPE could harness the voices of people, families, and communities, informing new models of care, delivery, and reimbursement that encompass interprofessional, integrated health and social care.

Research

The need for an interprofessional approach to shared decision-making (Stacey et al., 2010) provides an opportunity to develop, test, and evaluate new SDM models. In research, SB-IPE could harness the voices of people, families, and interprofessional teams to develop a new model of interprofessional SDM. Stacey recommended the "need for a model that is inclusive of an interprofessional approach to SDM" (2010, p. 171). Narrative approaches offer a pathway toward the development of an SDM process inclusive of the voice of people, families, and interprofessional practitioners. "If narrative methods, patient-centered practice, and interprofessional teamwork have one thing in common, it is the accurate and complete co-construction of the patient's story of his or her own life as it is related to health and social care" (Clark, 2015, p. 180).

Theory

In 1996, Saleebey stated that the strengths perspective was "[c]learly not a theory. But its emerging body of principle and method does create opportunities for professional knowing and doing…so common today" (p. 303). By 2009, Saint-Jacques, Turcotte, and Pouliot titled an article, *Adopting a Strengths Perspective in Social Work Practice with Families in Difficulty*: *From Theory to Practice*, implying that the perspective had moved into the realm of theory. By 2011, James stated that "Strengths theory emerged as a perspective in social work discourse as an alternative to the psychoanalytic model of analysis and intervention. In practice, strengths theory is now accepted broadly in health sciences" (p. 224). Given the 30th anniversary of the strengths perspective in social work and its extensions to other fields and contexts, perhaps it's time to re-evaluate the strengths perspective for consideration as a practice theory.

Five-hundred years ago, after closely observing trees, Leonardo DaVinci noticed that "when trees branch, smaller branches have a precise mathematical relationship to the branch from which they sprang" (Palca, 2011, para 3). Similarly, a strengths-based approach to interprofessional practice and education (SB-IPE) can branch from the tree of the strengths perspective, fed by the nutrients of appreciative inquiry and narrative to elicit, co-create, and coalesce the voices of people, families, and communities with that of members of the interprofessional team.

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